

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031691

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 96

FILED AUG 26 1963

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Liberty		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Odd Fellow's Hospital		d. STREET ADDRESS (If outside, give location) 1100 West 93rd Terr.	
3. NAME OF DECEASED (Type or print) First WALTER Middle JAMES Last PACKER		4. DATE OF DEATH Month August Day 18 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Ft. Scott, Kansas	
11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Colvin Packer		13b. MOTHER'S MAIDEN NAME Annie E. Beam	
14. NAME OF HUSBAND OR WIFE Georgia Packer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Mrs. Georgia Packer 1100 West 93rd Terr.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Emphysema			INTERVAL BETWEEN ONSET AND DEATH 7
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION			COUNTY _____ STATE _____
21. I attended the deceased from Aug 17 to Aug 18 and last saw him alive on Aug 18 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wm. J. Anderson M.D.			22b. ADDRESS Liberty, Mo.
22c. DATE SIGNED 8/19/63			22d. ADDRESS [REDACTED]
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-21-63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) Kansas City, Missouri		23e. DATE RECD. BY LOCAL REG. 8-20-63	
24. FUNERAL DIRECTOR Freeman Mortuary		25. REGISTRAR'S SIGNATURE Mabel Graham	

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

1 6002
2 7000
3
4 0
5 1
6
7 1
8 0
9 4500
10
11
12 860
13 30

MR. GOOSON
ODD FELLOWS HOSEA
LIBERTY, MO.

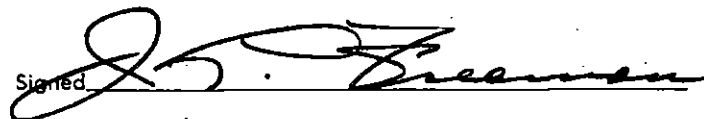
12-4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 2939

P. O. Address F. O. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.